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**BEFORE THE**
**BOARD OF REGISTERED NURSING**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>BELINDA THOMAS<br>43861 Elm Avenue<br>Lancaster, CA 93534<br>Registered Nuring License No. 416123<br><br>Respondent. | Case No. 2009-122<br><br>**ACCUSATION** |

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about August 31, 1987, the Board issued Registered Nursing License Number 416123 to Belinda Thomas (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2009, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 118, subdivision (b) of the Code provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 490 of the Code states in pertinent part: "A board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere."

6. Section 2750 of the Code provides in pertinent part that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

"(d) Violating or attempted to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter or regulations adopted pursuant to it.

. . . .

"(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof."

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8. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, . . . or . . . administer to himself or herself . . . any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

"(c) Be convicted of a criminal offense involving the . . . consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section . . . in which event the record of the conviction is conclusive evidence thereof.

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. Section 2764 of the Code provides in pertinent part that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

10. Section 125.3 of the Code provides in pertinent part that the Board may request the administrative law judge to direct a licentiate found to have committed licensing act violations to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES

11. Demerol is a Schedule II controlled substance as defined in Health and Safety Code section 11055, subdivision (c)(17) and is characterized as a dangerous drug pursuant to section 4022 of the Code.

12. Ativan is a Schedule IV controlled substance as defined in Health and Safety Code section 11057, subdivision (d)(16) and is characterized as a dangerous drug pursuant to section 4022 of the Code.

13. Morphine sulfate is a Schedule II controlled substance as defined in Health and Safety Code section 11055, subdivision (b)(1)(M) and is characterized as a dangerous drug pursuant to section 4022 of the Code.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct -- Drug Diversion)

14. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a) and 2762, subdivisions (a) in that Respondent has diverted controlled substances from her former employer Antelope Valley Hospital, from on or about July 5, 2000 through on or about July 28, 2000, failing to account for over 2,325 milligrams of Demerol, 2 milligrams of Ativan and 2 milligrams of Morphine Sulfate. The circumstances are as follows:

a. On or about July 5, 2000, at Antelope Valley Hospital, the physician's order from Dr. N. for Patient HB, CCU Room/Bed 206-20, provided for 25 milligrams' Demerol "q1" (i.e., every hour) "prn" (i.e., as needed), and the physician's order from Dr. C., noted at 15:30 (i.e., 3:30 p.m.) provided for 50 milligrams' Demerol "IVP q204 hours prn" (i.e., intravenous every two to four hours as needed). Per the pyxis report, Respondent withdrew a total of 450 milligrams' Demerol, and wasted 25 milligrams. The Medication Administration Record (MAR) reflected that Respondent had administered 150 milligrams' Demerol, and 275 milligrams were unaccounted.

b. On or about July 6, 2000, at Antelope Valley Hospital, the flow sheet indicated that Patient HB was given 25 milligrams' Demerol intravenously, that his "BP" (i.e., blood pressure) at 7:30 a.m. was 48/26 and that his "RR" (i.e., respiratory rate) was 28. At 8:20

a.m., Patient HB was pronounced dead.

c. On or about July 13, 2000, at 9:15 a.m., at Antelope Valley Hospital, the physician's order from Dr. K. for Patient RK provided for 25 milligrams' Demerol "IVP q1-2 hours prn" (i.e., intravenously every one to two hours as needed). Prior to Dr. K's order, Respondent signed out 2 doses of Demerol at 0800 (i.e., 8:00 a.m.) and 0830 (i.e., 8:30 a.m.) At 13:30 (i.e., 1:30 p.m.), the physician's order from Dr. Y. provided for 25 milligrams' Demerol "q 30 min - 1hr prn" (i.e., intravenous every thirty minutes to one hour as needed). Per the pyxis report, Respondent withdrew a total of 500 milligrams' Demerol, and wasted 25 milligrams. The MAR reflected that Respondent had signed out 375 milligrams' Demerol, and 100 milligrams were unaccounted.

d. On or about July 14, 2000, Patient RK's blood pressure was documented as low all day. At 1200 (12:00 a.m.), Respondent continued to medicate Patient RK "q 30 minutes" (every 30 minutes) with the patient's blood pressure in the 79-80s systolic (i.e., the blood pressure when the heart is contracting), and the patient was on Dopamine at the dose of 25 mcg/kg/min (i.e., 25 micrograms per minute). At 1610 (i.e., 4:10 p.m.), Dr. Y turned off the Dopamine, and Patient RK received 25 milligrams of Demerol intravenously. At 1614 (i.e., 4:14 p.m.), Dr. Y gave a verbal order written by Respondent for Patient RK allowing the administering of Demerol "q 15 min" (every 15 minutes) per family request, with the family adamant that the patient pass away peacefully. At 1645 (4:45 p.m.), Patient RK was given 25 milligrams' Demerol intravenously. At 1700 (5 p.m.), Patient RK's blood pressure was 33/24, and his respiratory rate was 22, with the patient unresponsive. The MAR indicated that 25 milligrams' Demerol were given intravenously. At 1710 (i.e., 5:10 p.m.), Patient RK's heart rate was 41 and blood pressure was 21/19, with no spontaneous respirations. The MAR indicated that 25 milligrams' Demerol were signed out for 1715 (i.e., 5:15 p.m.). Even though Patient RK was pronounced dead at 1745 (i.e., 5:45 p.m.), at 1831 (i.e., 6:31 p.m.), per the pyxis report, 100 milligrams' Demerol were withdrawn under Patient RK's name. The pyxis report indicated that Respondent withdrew a total of 800 milligrams' Demerol under Patient RK's name, and that Respondent wasted 50 milligrams. The MAR indicated that Respondent administered 575

milligrams' Demerol to Patient RK, with 175 milligrams unaccounted for.

e. On or about July 20, 2000, at 845 (i.e., 8:45 a.m.) at Antelope Valley Hospital, the physician's order from Dr. K. for Patient AC provided for 25 milligrams' Demerol "IVP q1 hour prn" (i.e., intravenously every hour as needed). At 1400 (i.e., 2 p.m.), Respondent put a call out to Dr. D. regarding whether Patient AC should be on Demerol with renal insufficiency, but she still gave Demerol at 2 p.m., 2:30 p.m., 3 p.m., 3:30 p.m. and 4 p.m. Contrary to the physician order, the MAR indicated Demerol to be administered "Q 30-1 hour prn" (every half hour to one hour as needed). Per the pyxis reports, Respondent took out 400 milligrams' Demerol, and wasted 50 milligrams. The MAR reflected that Respondent had administered 200 milligrams' Demerol, and 150 milligrams were unaccounted.

f. On or about July 20, 2000, at Antelope Valley Hospital, at 0745 (7:45 a.m.) and 0855 (8:55 a.m.), 50 milligrams each of Demerol was signed out with respect to Patient AL, but there was no written note regarding the name of the sedation, the times of sedation or who administered the Demerol. Per the pyxis report, Respondent withdrew 350 milligrams of Demerol under Patient AL. The MAR reflected that Respondent had administered 100 milligrams' Demerol, and 250 milligrams were unaccounted.

g. On or about July 20, 2000, at Antelope Valley Hospital, Respondent failed to account for 2 milligrams of Ativan for Patient AL. Per the pyxis report, at 13:38 (1:38 p.m.), Respondent withdrew 2 milligrams of Lorazepam/Ativan without wastage. The MAR does not reflect that Respondent administered this controlled substance to Patient AL.

h. On or about July 22, 2000, at Antelope Valley Hospital, per the pyxis report, Respondent removed 600 milligrams' Demerol under Patient JB. The MAR reflected that Respondent had administered 450 milligrams' Demerol, and 150 milligrams were unaccounted.

i. On or about July 23, 2000, at Antelope Valley Hospital, per the pyxis report, Respondent removed 800 milligrams' Demerol under Patient JB. The MAR reflected that Respondent administered 700 milligrams' Demerol, and 100 milligrams were unaccounted.

j. On or about July 27, 2000, at 07:44 (7:44 a.m.) at Antelope Valley

Hospital, per the pyxis report, Respondent removed 4 milligrams of Morphine Sulfate for Patient RH without wastage. The MAR reflected that at 07:45 Respondent administered 2 milligrams of Morphine Sulfate.

k. On or about July 27, 2000, at Antelope Valley Hospital, the doctor's order for Patient RH, CCU 209, was for 25 mg IV q hr prn (i.e., 25 milligrams intravenously every hour as needed) of Demerol. While Patient RH was under Respondent's care from 0700 (i.e., 7 a.m.) to 1300 (i.e., 1 p.m.), four doses of Demerol were documented as given between 0810 (8:10 a.m.) and 1000 (i.e., 1 p.m.), and four doses of Demerol were documented as given between 1055 (10:55 a.m.) and 1200 (12 noon), twice as much ordered. Between 1400 (2 p.m.) and 1900 (7 p.m.), according to the MAR and another nurse's narrative notes, Respondent removed Demerol from pyxis and administered four doses of Demerol. Per pyxis, Respondent removed 875 milligrams of Demerol. The MAR reflected that Respondent administered 300 milligrams of Demerol, and 575 milligrams were not accounted. The documentation as to when Demerol was given on the MAR did not consistently match the narrative notes or the Pyxis report from 0700 (7 a.m.) to 1300 (1 p.m.).

l. On or about July 28, 2000, at Antelope Valley Hospital, when Patient RH was still on CCU (Critical Care Unit) 2, on the opposite CCU than the CCU 1, eight out of ten does of Demerol were removed from the CCU 1 pyxis. Although Respondent did not care for Patient RH on July 28, 2000, 50 milligrams' Demerol were documented on the MAR and removed from the pyxis. Narrative notes indicated that Respondent removed 400 milligrams of Demerol from the CCU 1 pyxis under the name of Patient RH, who was on the opposite side. The 400 milligrams were not accounted for.

m. On or about July 28, 2000, at 1040 (10:40 a.m.) at Antelope Valley Hospital, there was a handwritten note in Respondent's writing that there was a telephone physician's order from Dr. G. for Patient RC, CCU Room 210, providing for 50 milligrams' Demerol IVP q1 hour prn" (i.e., intravenously every hour as needed). There was no documentation in the Nurses Narrative notes that Dr. G. was consulted regarding the Demerol order. Prior to the 10:40 a.m. order, the MAR reflected that Respondent signed out Demerol at

0820 (8:20 a.m.), 0920 (9:20 a.m.) and 0950 (9:50 a.m.). It was noted that there was a discrepancy in the number of times Demerol was signed out on the MAR to the number of times documented in the narrative. Although the time interval for administering Demerol was 50 milligrams q 1 hourly (every hour), Demerol was given less than every hour to Patient RC, specifically at 1040 (10:40 a.m.), 1125 (11:25 a.m.) and 1200 (12 noon). Per the pyxis report, Respondent withdrew a total of 600 milligrams' Demerol. The MAR reflected that Respondent had administered 450 milligrams' Demerol, and 150 milligrams were unaccounted.

SECOND CAUSE FOR DISCIPLINE

(Incompetence and/or Gross Negligence)

15. Respondent is subject to disciplinary action under Code sections 2750 and 2671, subdivision (a)(1) in that she engaged in incompetence or gross negligence in carrying out her nursing functions. The circumstances are that Respondent medicated patients more frequently than ordered by the physician, and made grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital patient records pertaining to the controlled substance of Demerol. Complainant refers to and by this reference incorporates the allegations set for in paragraph 14, subparagraphs (a) through (m) inclusive, above, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Abuse of Controlled Substances)

16. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a) and 2762, subdivision (b) in that she used a controlled substance, Demerol, and alcohol to an extent or in a manner dangerous or injurious to herself, any other person, or the public, or to the extent that such use impaired her ability to conduct with safety to the public the practice authorized by her Registered Nurse License. The circumstances are as follows:

a. In or around the summer of 2000, Respondent was admittedly addicted to and abusing Demerol.

b. On or about November 16, 2005, Respondent was arrested for driving under the influence of alcohol (Veh. Code, § 23152). While in a doctor's office with her minor

daughter, Respondent smelled of alcohol and could only stand with the help of her daughter holding her up.

FOURTH CAUSE FOR DISCIPLINE

(Conviction for Substantially Related Crime)

17. Respondent is subject to disciplinary action under Code sections 490 and 2761, subdivision (f) in that she has a conviction for a crime substantially related to the qualifications, functions, or duties of a registered nurse. The circumstances are as follows:

a. On or about February 27, 2006, after entering a plea of nolo contendere, Respondent was convicted of violating Vehicle Code section 23152, subdivision (b) (driving under the influence of alcohol with a blood alcohol content of .08 percent or more). This conviction stems from the November 16, 2005 arrest set forth in paragraph 16, subparagraph (b), which Complainant refers to and, by this reference, incorporates as though set forth fully.

FIFTH CAUSE FOR DISCIPLINE

(Conviction for Controlled Substances-Related Crime)

18. Respondent is subject to disciplinary action under Code section 2762, subdivision (c) in that she was convicted of a crime involving the consumption or self-administration of substances described in subdivision (b) of section 2762. Complainant refers to and by this reference incorporates the allegations set forth in paragraph 17, subparagraph a inclusive, above, as though set forth fully.

SIXTH CAUSE FOR DISCIPLINE

(False Hospital Record Entries Regarding Controlled Substances)

19. Respondent is subject to disciplinary action under Code section 2762, subdivision (e) in that Respondent falsified, or made grossly incorrect, grossly inconsistent or unintelligible entries in any hospital, patient or other record pertaining to substances described in subdivision (a) of this section. Complaint refers to and by this reference incorporates the allegations set forth in paragraph 14, subparagraphs (a) through (m) inclusive, above, as though set forth fully.

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## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Respondent's Registered Nursing License Number 416123;

2. Ordering Respondent to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 11/26/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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